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BULLETIN NO. 1, VOL. 1 SEPTEMBER 18, 2008

HCQCC Update: Patient Safety

Working with a broad coalition of state health care leaders, the Health Care Quality and Cost Council (HCQCC) is pleased to report the progress and implementation of several new programs, initiatives and regulations designed to improve patient safety. With an overall mission to improve health care quality and reduce costs, patient safety is an important area of focus for the Council.

In April, 2008 the HCQCC approved the following recommendations to "ensure patient safety and effectiveness of care:

- Eliminate hospital-associated infections by 2012;
- Eliminate "Serious Reportable Events" (wrong surgery, wrong site, wrong patient) as defined by the National Quality Forum; and
- Identify and adopt a meaningful measure of whole system quality and safety, including a whole system mortality measure.

Progress on Goals and Recommendations

Together, state government, health care providers, payers, and non-profit organizations have undertaken a number of significant steps to meet these aims:

Health Care Associated Infections and Serious Reportable Events

- The legislature and Governor passed a law requiring hospitals to report health care associated infections (HAIs) and serious reportable events (SREs) to the Department of Public Health (DPH) and calls for the publication of these reports on the HCQCC consumer friendly website.
- Following the Council's recommendation, DPH will issue its first public report on aggregate SRE occurrences at Massachusetts hospitals in October, 2008. A report on SRE occurrences at individual hospitals will follow in April, 2009.
- Under the leadership of Secretary JudyAnn Bigby, the Executive Office of Health and Human Services determined that state-sponsored insurance programs such as MassHealth, the Commonwealth Connector Authority, and the Group Insurance

Commission, will no longer pay for SREs. Nor will the state allow health care providers to bill members for these occurrences.

- DPH will require all state hospitals to develop fall prevention plans, which will be publicly posted and subject to DPH review and evaluation. Falls constitute over half of reported SREs.
- The Partnership for Healthcare Excellence started a campaign to help consumers reduce their risk of infection in the hospital and in their daily lives. The Partnership, together with DPH, developed two fact sheets on infection prevention that are currently available at www.partnershipforhealthcare.org.
- On July 1, 2008, the DPH began requiring hospitals to report hospital-associated infections to the Center for Disease Control.
- The Massachusetts Coalition for the Prevention of Medical Errors launched a series of educational and outreach efforts designed to eliminate HAIs in Acute Care hospitals. Their work includes engaging hospital leadership on infection prevention and supporting the HCQCC's charge that hospitals implement the recommendations of the Betsy Lehman Center Expert Panel for the Prevention and Control of Healthcare-Associated Infections and the National Quality Forum's Endorsed State Practices for Better Healthcare.
- In early 2008, the Massachusetts Hospital Association implemented a policy under which hospitals would not bill for 11 of the 28 SREs.

Hospital Mortality Measure

- At the request of the HCQCC, the Division of Health Care Finance and Planning convened an Expert Panel to select a whole system hospital mortality measure. This measure will be publicly reported for individual hospitals in January 2010.

What's Next?

On behalf of the HCQCC, the Massachusetts Coalition for the Prevention of Medical Errors and the Massachusetts Long Term Care Foundation conducted a survey to catalogue current patient safety initiatives. This survey revealed a potential gap surrounding "transitions of care," i.e. times when patients are transferred from one level of care (or location) to another. In response, the Council will partner with the Coalition and the Massachusetts Care Transitions Task Force to make transitions of care a future patient safety focus.

Community Spotlight on Patient Safety

- Your local hospital has a patient safety program. What are they doing to prevent SREs and HAIs? Contact the Massachusetts Hospital Association (www.mhalink.org) or call your hospital directly to find out.

About the Health Care Quality and Cost Council

Chapter 58 of the Acts of 2006 establish The Massachusetts Health Care Quality and Cost Council to identify statewide goals for improving health care quality, containing health care costs, and reducing racial and ethnic disparities in health care and to demonstrate progress toward achieving those goals. The Council is also responsible for disseminating, through a consumer-friendly website and other media, comparative health care cost, quality, and related information for consumers, health care providers, health plans, employers, policy-makers, and the general public.

For additional information about the Health Care Quality and Cost Council and to obtain a copy of the Annual Report, please visit: *www.mass.gov/healthcare.*